BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Marcos Yuo Cheng Yang, M.D.	)	Case No. 800-2015-017041
Physician's and Surgeon's Certificate No. A 49035	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 3, 2019.

IT IS SO ORDERED: April 5, 2019.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARCOS YUO CHENG YANG, M.D.** **310 Tejon Place** **Palos Verdes Estates, CA 90274** **Physician's and Surgeon's Certificate No. A 49035,** Respondent.	Case No. 800-2015-017041 OAH No. 2018050834 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Christina Sein Goot, Deputy Attorney General.

2. Respondent Marcos Yuo Cheng Yang, M.D. (Respondent) is represented in this proceeding by attorney Derek F. O'Reilly-Jones of Bonne Bridges Mueller O'Keefe & Nichols,

whose address is: 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071.

3. On or about December 17, 1990, the Board issued Physician's and Surgeon's Certificate No. A 49035 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-017041, and will expire on July 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2015-017041 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 6, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2015-017041 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-017041. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation

No. 800-2015-017041 and that he has thereby subjected his license to disciplinary action.

10. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2015-017041 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 49035 issued to Respondent Marcos Yuo Cheng Yang, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in

advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of

this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring

responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's place of residence, or in a patient's place of residence on a regular basis, unless the patient resides in a skilled nursing facility or other similar licensed facility. This provision shall not preclude Respondent from seeing the very limited number of hospice patients who require care in their own homes, or from making occasional house calls to patients who develop temporary difficulties attending regular in-office examinations. Respondent's practice monitor shall review medical records from

all in-home consultations Respondent performs as part of his or her required quarterly review.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent

shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Derek F. O'Reilly-Jones. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 1/28/2019

MARCOS YUO CHENG YANG, M.D.
Respondent

I have read and fully discussed with Respondent Marcos Yuo Cheng Yang, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 1/28/2019

DEREK F. O'REILLY-JONES
Attorney for Respondent

[Endorsement on following page]

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 4/30/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

CHRISTINA SEIN GOOT
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-017041

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Mar 6 20 18
BY D. Richards ANALYST

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Marcos Yuo Cheng Yang, M.D. 310 Tejon Place Palos Verdes Estates, CA 90274 Physician's and Surgeon's Certificate No. A 49035, Respondent.	Case No. 800-2015-017041 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about December 17, 1990, the Medical Board issued Physician's and Surgeon's Certificate Number A 49035 to Marcos Yuo Cheng Yang, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2018, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following

laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. The Medical Practice Act ("Act") is codified at Business and Professions Code, Section 2000 et seq.

5. Pursuant to Code section 2001.1, the Board's highest priority is public protection.

6. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

7. Code section 2227, subdivision (a), provides as follows:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

8. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

9. Section 2238 of the Code states: "A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTS

Patient 1:[1]

11. Patient 1 has been Respondent's patient since 2002, and was treated for various issues including hemorrhoids and headaches. The records show that Patient 1 developed intermittent headaches after failed surgeries in the 1990's. Respondent treated her headaches with hydrocodone.[2]

12. The records indicate that Patient 1's pain spread throughout her arms and legs and she was diagnosed with systemic lupus, multiple sclerosis, and fibromyalgia by a series of other physicians, including pain management specialists who started her on opioid therapy in 2010.

13. In 2012, Patient 1 requested that Respondent refill the narcotic prescriptions from these other physicians. The pain medications included monthly prescriptions for Oxycodone[3]

[1] Patients are identified by number to protect patient privacy.

[2] Hydrocodone is a narcotic drug derived from codeine used in its bitartrate form as an analgesic and antitussive.

[3] Oxycodone is a semisynthetic opioid drug used in its hydrochloride form as a pain

5mg # 360[4] and timed release OxyContin[5] 60mg # 150. The daily total Oxycodone dosage is 360mg, a morphine equivalent dosage (MED) of 540mg.

14. From 2012 to 2016, Patient 1 was routinely prescribed narcotic pain medications every 2 to 3 weeks. Respondent provided early refills during periods when Patient 1 stated that her pain was much worse. Detailed musculoskeletal examinations were seldom done. The few cursory examinations that were done showed a full range of motion of the neck and shoulders with some tenderness and no joint swelling.

15. On August 21, 2013, medical records reflect Respondent's suspicion of Patient 1's drug abuse. Respondent recommended that Patient 1 see addiction medicine specialists. However, Patient 1 refused and controlled substance prescriptions were refilled again at the same quantity. Respondent did not present a plan to reduce Patient 1's opioid regimen.

16. In September 2013, Patient 1 started receiving additional Oxycodone 30mg # 150 to #180 from Respondent. By mid-2016, her daily Oxycodone regimen averaged about 540mg daily. This is a MED of 810mg daily. This pattern of narcotic prescribing continued until late 2016 when Respondent terminated his patient/doctor relationship with Patient 1 due to her noncompliance with pain management consults and drug addiction programs. Throughout the four years of Respondent's narcotic prescribing to Patient 1 the medical records contain no pain care agreements, informed consent documents, urine drug testing results or CURES queries.

17. During his treatment of Patient 1, Respondent also prescribed Alprazolam[6] and Nuvigil.[7] The Respondent's CURES report shows that these medications were started in 2012 and continued throughout Patient 1's care until the termination of the patient/doctor relationship. No anxiety screening questionnaire is in the medical records and no medical diagnosis and/or

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reliever, often in combination with nonopioid analgesics such as acetaminophen.

[4] The shorthand "5mg # 360" means 5 milligrams with a quantity of 360 tablets. This shorthand form is used throughout this Accusation.

[5] OxyContin is an opiate drug, oxycodone hydrochloride, used as a painkiller and, illegally, as an alternative to heroin.

[6] Alprazolam is a benzodiazepine drug used to treat panic disorder and other anxiety disorders.

[7] Nuvigil is a central nervous system stimulant used to improve wakefulness in patients with excessive daytime drowsiness due to narcolepsy, obstructive sleep apnea/hypopnea syndrome and shift work disorder.

evaluation is present in the medical records to indicate a reason for prescribing Alprazolam or Nuvigil.

18. A review of Respondent's CURES report shows that Respondent was prescribing Oxycodone, Oxycontin, Alprazolam and Nuvigil to Patient 1 in 2012. The prescriptions were given every two to three weeks and filled at several different pharmacies. The prescriptions were refilled early on numerous occasions. In addition, duplicate narcotic prescriptions by Respondent were provided to Patient 1 on November 4, 2013, November 15, 2013, December 19, 2013 and January 29, 2014.

19. In 2014, Patient 1 received 420 tablets of hydrocodone from her podiatrist and dentist. In fact, duplicate hydrocodone prescriptions were given on June 26, 2016, by different doctors. Respondent did not review a CURES report to detect this drug seeking behavior. Patient 1's Alprazolam dosage was constant at 0.5mg daily every other month. Patient 1's Nuvigil dosage was also constant at about 150mg daily from 2013 to 2016.

20. Other physicians allegedly diagnosed Patient 1 with lupus, fibromyalgia and multiple sclerosis. However, there were no consultation notes in the charts confirming these diagnoses with other physicians and there was no review of Patient 1's previous records to confirm these disabling diagnoses.

21. Respondent did not order radiological testing to evaluate Patient 1's joints. Systemic lupus and multiple sclerosis can cause progressive disability, but Patient 1 did not have frequent clinical follow up with rheumatology and neurology specialists.

22. Respondent's medical records indicate that Patient 1 was never diagnosed with sleep apnea or narcolepsy, but was given Nuvigil to stay awake enough to take care of her family. Respondent failed to realize that Patient 1's daytime fatigue and sleepiness could be related to her usage of excessive narcotic medications. The medical records do not reflect a proper indication for this Nuvigil.

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Patient 2:

23. Patient 2 is a fifty-five-year-old male with hypertension[8] and hyperlipidemia[9] who was first seen by Respondent in 2000. CURES reports reveal that Patient 2 regularly received 10 mg #120 of hydrocodone monthly from 2014 through 2016. This is 40mg of hydrocodone daily, equivalent to MED of 40mg. Concurrently, Patient 2 was prescribed muscle relaxants for his chronic low back pain. He had a lumbar and thoracic spine MRI in 2012 showing disc herniation and degenerative spine disease with foraminal stenosis. In 2015, he was seen by an infectious disease consultant and diagnosed with chronic viral/fatigue syndrome. The charts also included a pain management consultation in August 2016, by Dr. B., who recommended him to continue the same opiate therapy for the back pain.

24. Patient 2 was diagnosed with "generalized anxiety," but no specific details, symptoms or functional limitations of the condition were documented and no screening questionnaire for anxiety was done. There was no psychiatric consultation in the records. Patient 2 was prescribed Diazepam[10] 10mg daily with SSRI[11] Cymbalta.[12] Patient 2 also received 6 prescriptions of Adderall from 2014 through 2016 at 10mg daily. No physical therapy or surgical consultations are reflected in the chart. Nor were there any urine drug testing or a pain management agreement in the charts.

25. Patient 2's CURES data from 2014 through 2016 showed regular monthly prescriptions of hydrocodone 10mg #120 and Diazepam 10mg #30. There were six prescriptions for Adderall 10mg daily. Zolpidem[13] 10mg nightly was regularly prescribed through 2016.

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[8] Hypertension is high blood pressure. Blood pressure is the force of blood pushing against the walls of arteries as it flows through them. Arteries are the blood vessels that carry oxygenated blood from the heart to the body's tissues.

[9] Hyperlipidemia is an excess of fats or lipids in the blood.

[10] Diazepam, first marketed as Valium, is a medication of the benzodiazepine family that typically produces a calming effect. It is commonly used to treat a range of conditions including anxiety, alcohol withdrawal syndrome, benzodiazepine withdrawal syndrome, muscle spasms, seizures, trouble sleeping, and restless legs syndrome.

[11] SSRI means any of a class of drugs, such as fluoxetine or sertraline, that inhibit the reuptake of serotonin by neurons of the central nervous system and are primarily used in the treatment of depression and obsessive compulsive disorder.

[12] Cymbalta is the SSRI duloxetine hydrochloride.

[13] Zolpidem is a sedative/hypnotic drug useful for treating anxiety and resembling benzodiazepines in its pharmacology but differing somewhat in chemical structure. Unlike

26. Respondent's records reflect that Patient 2 was treated for chronic pain from 2013 until 2016. However, Respondent's records do not reflect any evidence of an evaluation for non-opiate management of chronic pain for Patient 2. The records show that Patient 2 had normal renal function and could have benefitted from NSAIDS[14] and tricyclics[15] and anti-seizure medications to help control his chronic low back pain.

27. Respondent's records show that Patient 2 was not referred for physical therapy and spinal manipulation or other treatments for his chronic low back pain.

28. Respondent's records show that no risk stratification assessment of Patient 2 occurred prior to initiating opiate therapy. Respondent then failed to properly assess the opiate analgesic effect and the functionality and the goals of treatment with Patient 2 at any of the subsequent visits by the patient. Prescription refills were simply written and handed to the patient for his monthly 120 tablets of hydrocodone. Respondent did no urine drug testing for aberrant behaviors or queries with the CURES database for Patient 2.

29. Respondent's records show that he never had a formal discussion with Patient 2 about the risks of long term opiate therapy and never executed a pain care agreement outlining the patient's responsibilities and understanding of the dangerous opiate medications.

30. Patient 2 was prescribed Diazepam for a generalized anxiety disorder for many years. The combination of hydrocodone and Diazepam increased risks of accidental overdose and the risk of respiratory failure. Respondent also prescribed the sleeping medication Zolpidem[16] in 2016, which could increase respiratory risks by suppressing the respiratory center.

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benzodiazepines, zolpidem lacks prominent anticonvulsant properties, and less tolerance may develop with its use.

[14] NSAIDs are nonsteroidal anti-inflammatory drugs used to treat or reduce inflammation. "Nonsteroidal" means they do not contain hormones, unlike some other types of anti-inflammatory drugs.

[15] A Tricyclic is any of a class of drugs with particular tricyclic structure and potentiating catecholamine action used for the treatment of depression. This antidepressant contains three fused rings or closed chains in the molecular structure.

[16] Zolpidem is a non-benzodiazepine sleep-inducing drug used in its tartrate form to treat insomnia.

31. Respondent did not taper Patient 2 off benzodiazepine and did not obtain a psychiatric consultation to help in the tapering process and to optimize the treatment of his anxiety disorder.

32. Patient 2's medical records contain no indication justifying the prescribing of Adderall yet Respondent prescribed Adderall to Patient 2.

Patient 3:

33. Patient 3 first saw Respondent in 2004. Patient 3's right ankle was operated on several times and he received Oxycodone for the pain. Patient 3 also informed Respondent that he had generalized anxiety disorder and had tried several SSRI anxiety medications previously. Patient 3 informed Respondent that nothing controlled his symptoms except Alprazolam 2mg four times daily. From 2004 to 2016, Patient 3 took 8mg of Alprazolam daily for management of his anxiety.

34. Respondent started Methadone[17] therapy for the patient in 2005 at 10mg twice daily. Patient 3's dosage was eventually increased to 10mg four times daily. A CURES report from 2014 - 2016 showed that Patient 3 regularly received monthly prescriptions of Methadone at 40mg daily and Alprazolam at 8 mg daily.

35. Respondent provided Patient 3 intermittent prescriptions of Diazepam for muscle spasms from 2013 though 2016. In September 2016, during a clinic visit for a refill, Respondent informed Patient 3 that the CURES report showed that Patient 3 was receiving additional narcotic pain medication from a different physician. Respondent informed Patient 3 he would start tapering his pain medication and referred Patient 3 to an addiction specialist and a pain management specialist.

36. Respondent's medical records indicate that he never had a formal discussion with Patient 3 about the risks of long term opiate therapy. Respondent and Patient 3 never executed a pain care agreement outlining the patient's responsibilities and understanding of the dangerous

[17] Methadone, sold under the brand name Dolophine, among others, is an opioid used to treat pain and as maintenance therapy or to help with tapering in people with opioid dependence. Detoxification using methadone can either be done relatively rapidly in less than a month or gradually over as long as six months. Methadone is usually taken by mouth and rarely by injection into a muscle or vein.

opiate medications. Respondent completed additional hours of pain management training in February 2016, but continued to prescribe narcotic medications to Patient 3 without informed consent and a pain care agreement contract in late 2016.

37. Starting in 2005, Respondent prescribed Methadone to Patient 3, which should be the opioid medication of last resort in chronic pain management. However, Respondent's records do not clearly show if the patient had failed all other opioid medications before the Methadone trial. The records do not contain evidence of an EKG to monitor the QT[18] interval done to ensure the safety of a patient taking this medication.

38. Respondent's medical records indicate that he failed to monitor the analgesic effect of the opiates prescribed to Patient 3. No proper assessments of functional improvement or treatment goals reached are contained in the records and no periodic urine drug tests to monitor compliance were done.

39. Respondent's medical records indicate that he failed to run CURES queries, but Respondent granted early refills to Patient 3 on 4 separate occasions where the patient lost his pain medication bottles or claimed to be going out of town.

40. Respondent's medical records indicate that he failed to have a formal discussion with Patient 3 about the risks of long term opiate therapy, and there was no executed pain care agreement outlining the patient's responsibilities and understanding of the dangerous opiate medications.

41. Respondent prescribed Patient 3 a daily dosage of 8mg of Alprazolam which was excessive, simultaneous with a prescription for Methadone, thereby increasing the patient's risks of respiratory compromise and accidental drug overdose.

42. Respondent's medical records indicate that he failed to taper Patient 3 off either Methadone or Alprazolam and failed to try non-benzodiazepine anxiolytics.

43. Respondent's medical records indicate that from 2013 to 2015, he unnecessarily increased the risks of accidental overdose by adding Diazepam intermittently to Patient 3's

[18] QT interval is the portion of an electrocardiogram between the onset of the Q wave and the end of the T wave, representing the total time for ventricular depolarization and repolarization.

regimen of Methadone and Alprazolam. The records indicate that the Diazepam was prescribed for muscle relaxation and back pain, but no non-benzodiazepine muscle relaxants were tried first to reduce the risks of overdose.

44. Respondent's medical records indicate that he failed to provide antidote therapy such as Naloxone[19] to Patient 3 to prevent a possible accidental overdose.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Gross Negligence)

45. By reason of the matters set forth above in paragraphs 11 through 44, incorporated herein by this reference, Respondent is subject to disciplinary action under section 2234, subdivision (b), in that Respondent was grossly negligent in the care and treatment of Patients 1, 2 and 3.

46. Respondent's incomplete evaluation of Patient 1's pain, failure to try non-opioid therapy, and his lack of close monitoring with rheumatology and neurology consults constitutes gross negligence.

47. Respondent's failure to risk stratify Patient 1 and his failure to properly monitor her opiate usage, perform routine urine drug tests, taper down her opiates and provide antidote therapy constitutes gross negligence.

48. Respondent's failure to risk stratify Patient 2, properly monitor his opiate usage, perform routine urine drug tests and run CURES queries constitutes gross negligence.

49. Respondent prescribed Adderall to Patient 2 despite no medical indication for that prescription, which constitutes gross negligence.

50. Respondent's failure to try safer opioids and his failure to routinely monitor the QT interval during Patient 3's Methadone therapy constitutes gross negligence.

51. Respondent's excessive prescriptions of Alprazolam, his intermittent additions of Diazepam for muscle relaxation, his failure to use non-benzodiazepine anxiolytic and muscle relaxants, and his failure to provide Naloxone therapy to Patient 3 constitutes gross negligence.

[19] Naloxone is an opioid antagonist structurally related to oxymorphone, used in the diagnosis and treatment of opioid toxicity, to reverse opioid-induced respiratory depression, and as an adjunct in the treatment of hypotension associated with septic shock.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Repeated Negligent Acts)

52. By reason of the matters set forth above in paragraphs 11 through 44, incorporated herein by this reference, Respondent is subject to disciplinary action under section 2234, subdivision (c), in that Respondent was repeatedly negligent in the care and treatment of Patients 1, 2 and 3.

53. Respondent's failure to discuss the effects of long-term opioid therapy with Patients 1, 2 and 3, and the lack of an informed consent and pain management contract constitutes negligence.

54. Respondent's failure to taper Patient 3 off Alprazolam and his failure to use non-benzodiazepine anxiolytics constitute negligence.

55. Respondent's prescribing of Nuvigil to Patient 1 without proper indication constitutes negligence.

56. Respondent's failure to use non-opioid therapies for Patient 2 constitutes negligence.

57. Respondent's failure to taper off Patient 2's benzodiazepine medication and the addition of Zolpidem constitutes negligence.

58. Respondent's failure to adequately monitor Patients 1, 2 and 3's opiate therapy and lack of routine urine drug testing and CURES queries constitutes negligence.

THIRD CAUSE FOR DISCIPLINE

(Violation of Drug Statutes)

59. By reason of the matters set forth above in paragraphs 11 through 44, incorporated herein by this reference, Respondent is subject to disciplinary action under section 2238, in conjunction with sections 2241 and 2242 of the Code in that he violated drug statutes during his care, treatment and management of Patients 1, 2 and 3.

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FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

60. By reason of the matters set forth above in paragraphs 11 through 44, incorporated herein by this reference, Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for Patients 1, 2 and 3.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 49035, issued to Marcos Yuo Cheng Yang, M.D.;

2. Revoking, suspending or denying approval of Marcos Yuo Cheng Yang, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Marcos Yuo Cheng Yang, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: March 6, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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